2004-2005
San Diego's "6 to 6" Extended School Day Program
Health History Form and Consent to Medical Treatment

Parent/ legal guardian must complete this form prior to child attending the program.

San Diego's "6 to 6" program operates on the school campus, however your child's health information is not shared between the provider agency and the school. In order for San Diego's "6 to 6" to provide the best possible service to your child, please fill in all necessary information**.**

CHILD'S NAME_____ SCHOOL_____

CHILD'S HEALTH HISTORY – PARENT'S REPORT

Is your child under the regular supervision of a physician? __Yes __No Date of last exam _____

Does your child currently have asthma or a medical condition that requires him/her to receive medication at school? __Yes __No
If yes, please describe:

_____

To request that "6 to 6" staff administer medication to your child while attending the "6 to 6" program, you must complete the "Authorization to Administer Medication Form" available from your site supervisor.

Specify any other illness, injury, or medical conditions about which staff should be aware of: _____

_____

Please list any allergies your child has: _____

San Diego's "6 to 6" program provides supervision of children in a 1 adult to 15 students ratio at elementary schools and 1 adult to 20 students ratios at middle schools.
__**yes** ___**no** Please check here if your child needs special accommodations due to a medical condition or disability. If there is anything the 6 to 6 staff should know regarding your child's condition, please include a written explanation with your enrollment forms. We want to be aware of any special needs so that you and your child will have a positive experience in the 6 to 6 program.

Parent's evaluation of child's health: _____

Parent's evaluation of child's personality: _____

Does your child have any special fears or challenges? _____

INSURANCE STATEMENT

Please initial one of the following and provide the required information.

___ My child has medical/dental insurance coverage with (insurance co./ HMO)_____

Policy # _____ Phone #_____

and

Policyholder's name (please print):_____

___ My child has Medi-Cal coverage. Medi-Cal ID#_____

___ My child has no medical/dental insurance coverage at this time.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Administrative procedures vary among medical facilities with regard to provision of medical care for a child in the absence of a parent. The exact procedures required by your preferred physician or hospital should be provided to San Diego's "6 to 6" Extended School Day staff in writing. In case of accident or an emergency, I authorize San Diego's "6 to 6" Extended School Day staff to facilitate the transport of my child to the physician named on the Emergency Information form, or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.

Parent's or Legal Guardian's Signature_____ **Date**_____